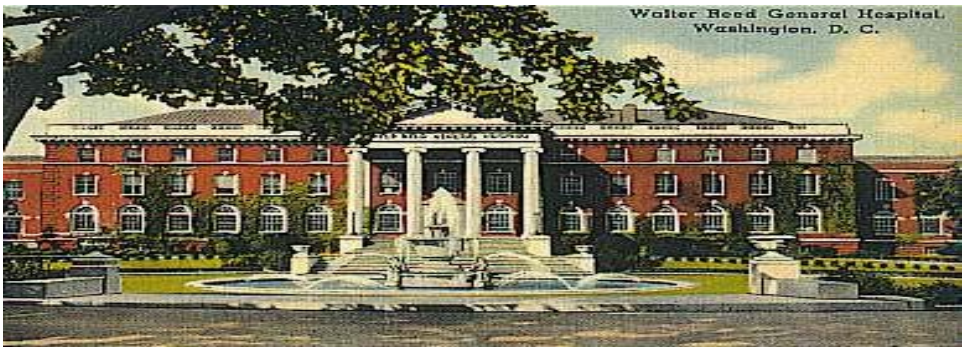
Walter Reed Cardiovascular Center



A Monthly Newsletter of the Cardiology Division of Walter Reed Army Medical Center

Commentary
Marina Vernalis, DO FACC

In response to requests, we have expanded our capabilities for direct referral to Walter Reed for routine stress testing without a "full" consultation. These "stress test only" appointments are available on Monday mornings and Wednesday afternoons. To schedule, simply call our EKG section at 202-782-2903 and request a standard treadmill stress test. Please ensure that the patient can walk adequately and that the EKG is interpretable. Contact any of our staff physicians if you have questions.

Cardiovascular Update
Daniel E. Simpson, MD FACC

Aspirin for Primary Prevention
Data continues to accumulate regarding the efficacy of daily aspirin therapy for prevention of cardiovascular events in patients without known atherosclerotic disease.

In the past year, both the United States Preventative Services Task Force (USPSTF) and the American Heart Association have made strong recommendations for aspirin in primary prevention based on a Framingham risk score of > 10% over 10 years.

A Clinical Practice review in the NEJM May 2002 suggests no aspirin if the annual risk is $\leq$ 0.6% and definite aspirin if the annual risk is $\geq$ 1.5%. Treatment of the mid-range risk patients is dependent upon patient preference, hypertension with target-organ damage or poor fitness.

Individual patient scores can be easily determined using the following calculator.

http://hin.nhlbi.nih.gov/atpiii/calculator.asp?usertype=pub

Importantly, low dose aspirin (81 mg) appears to be as effective as higher dose therapy with less bleeding.

As a result, many patients should be treated with aspirin as primary prevention against cardiovascular events given the favorable benefit to risk ratio.

*Ann Intern Med. 2002;136:161-172.
*Circulation. 2002;106:388-391.
*N Engl J Med. 2002;346:1468-1474.

Guideline Review
Daniel E. Simpson, MD FACC

Class I – General agreement that procedure/treatment is useful & effective
Class II – Conflicting evidence and/or divergence of opinion (a & b)
Class III – Not useful/effective and in some cases may be harmful

Beta-Blockers in AMI
B-adrenoceptor blockade reduces mortality and recurrent infarction, yet it remains under utilized. Some reviews reveal only 50% of patients receive this inexpensive and well-tolerated therapy. Likely 80-90% of patients are appropriate candidates.

Class I
1. Patients without a contraindication who can be treated within 12 hours of infarction, irrespective of administration of lytics or primary angioplasty.
2. Patients with continuing or recurrent ischemic pain.
3. Patients with tachyarrhythmias, such as AF with rapid ventricular response.
4. Non-ST elevation MI.

Class IIb
Patients with moderate LV failure (bibasilar rales without evidence of low cardiac output) or other contraindications, provided they can be monitored closely.

Class III
Patients with severe LV failure.

*ACC/AHA Guidelines for the Management of Patients With Acute Myocardial Infarction
www.acc.org/clinical/statements.htm

Cardiovascular Trials at WRAMC

ARBITER II
Comparison of niacin versus placebo in patients with CAD with an LDL < 130 on a statin and HDL < 45.

Questions/Referrals
Please contact Allen Taylor

CARDIASTAR
PFO closure device versus standard anti-coagulation therapy with coumadin in patients with an embolic TIA/CVA and no other etiology.

Questions/Referrals

Please contact Daniel Simpson